

Workgroup Assumptions and Recommendations

Assumption (asp.) / Recommendation (rec.)	Technical requirements to achieve	Feasibility (scale of 1-5; 5 being the most feasible)	Timeframe (scale of 1-5; 5 being the long term projects)	Comments
CI WG Rec 2.1: Priority consumer outcomes of HIE and HIT: <ul style="list-style-type: none"> Information exchange that improves patient care Appropriate consumer and provider access to health information Security of health information Improved communication among parties relevant to patient care Decision support that ensures appropriate care 				
CI WG Rec 2.2: Add ‘medical devices’ to high priority EHR/HIE data elements identified by patient care group.	New field?			
CI & PC WG Rec 2.3: Highlight the following data elements in patient care list as elements of added privacy concern:				
<ul style="list-style-type: none"> Identity/demographics/Master person index 	Master person index			Both the master person index and the master provider index require some decision about architecture – how would this data be stored? Locally? Centrally statewide?
	Provider index			
<ul style="list-style-type: none"> Diagnoses 	Diagnoses			
<ul style="list-style-type: none"> Medications 	Medications			

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▪ Allergies	Allergies			
▪ Labs and Other Diagnostics	Labs and Other Diagnostics			
▪ Procedures	Procedures			
▪ Patient visits and hospitalizations	Patient visits and hospitalizations			
▪ Discharge summaries and progress notes	Discharge summaries and progress notes			
▪ Payer/Insurance/Coverage and eligibility	Payer/Insurance/Coverage and eligibility			
PC WG Asp 2.3 While the workgroup ranked advance directives relatively low in its ranking of priority data elements, the expectation is that it will be included eventually. Current hospital information systems tend to answer the question of advance directives availability only in a yes/no format which requires going to another location to get the actual content of the directive. The goal is to have advance directive information incorporated into the electronic patient summary accessible through a common portal.				
CIWG Rec 3.1: In accordance with current Wisconsin law (providers <i>shall</i> share patient information for treatment purposes) patients will not be permitted to opt-out of including their general health information in Wisconsin's information exchange. Recommendations regarding the possibility of opting out of including more sensitive				

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information are in progress (see charge #4 in the progress report).				
CI WG Rec 3.2: Adopt Markle Foundation <i>Consumer and Patient Principles for System Design</i> as a template for recommendations related to access.				
<ul style="list-style-type: none"> Individuals should be able to access their health and medical data conveniently and affordably (#1) 				
<ul style="list-style-type: none"> Individuals should be able to decide (i.e., authorize) when their health data are shared, and with whom (#2) 		This suggests an opt-in/out strategy, which appears to be in conflict with CI WG Rec 3.1.		

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<ul style="list-style-type: none"> Individuals should be able to designate someone else, such as a loved one, to have access to and exercise control over how their records are shared (#3) 	Secure system with patient control over access			5
<ul style="list-style-type: none"> Individuals should receive easily understood information about all the ways that their health data may be used or shared (#4) 	Report mechanism			5
	Audit function			4
<ul style="list-style-type: none"> Individuals should be able to review which entities have had access to their personal health data (#5) 	Report mechanism			5
	Audit function			4
<ul style="list-style-type: none"> Electronic health data exchanges must protect the integrity, security, privacy, and confidentiality of an individual's information (#6) 	Secure system			
CI WG Rec 4.1: Add the following areas to discussion of sensitive health information: <ul style="list-style-type: none"> Adoption Developmental disabilities Sexual assault Domestic violence 				
CI WG Rec 4.2: Discussions should differentiate between areas delineated by HIPAA (treatment, health care operations, payment, public health).				
CI WG Rec 4.3: Current controlling law (Wisconsin law or HIPAA) should serve as the foundation for treatment of sensitive information (i.e., whether or not patients can opt-out or opt-in).				

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<p>Rec 4.4: Patients should be made aware of the risks and benefits of excluding their health information from exchange.</p> <p>Key concerns identified in discussions to date:</p> <ul style="list-style-type: none"> ▪ What is included in exchange ▪ Who has access to the information exchanged ▪ A patient/consumer's ability to influence (or limit) access ▪ Whether an individual is receiving routine or emergency care 	Opt-out	This suggests an opt-in/out strategy, which appears to be in conflict with CI WG Rec 3.1.		
G WG Asp 1.1: Some kind of structure or group is needed to oversee coordination of all of these initiatives across the private and public sectors.		No clear technology needs identified related to this item		
G WG Asp. 1.2: At a minimum, need a coordinating body for information sharing and to support these initiatives and have work of substance to do.		No clear technology needs identified related to this item		

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<p>G WG Asp 1.3: Some of the Wisconsin organizations are far ahead of what other states are trying to do and we need to start at this point and move forward.</p> <ul style="list-style-type: none"> ○ There is a lot of energy in some of these organizations. ○ Some fit together better than others and some things will happen at a different pace. ○ WHIO Board is now creating subcommittees to integrate new public reporting with existing public reporting underway in Wisconsin. ○ WHIO is too new to take this on at this time - needs to focus on its core mission. 		No clear technology needs identified related to this item		
<p>G WG Asp 1.4: Need very clear standards – and to wait to see what comes at a national level. Until this happens, HIT and HIE cannot move quickly. In the meantime there is excellent work underway and we don't want to slow it down.</p>	Technology standards	Efforts nationally, but what can be done at the state level to help accomplish this?		

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G WG Asp 1.5: One way to do this is to convene the leaders of key organizations to function as a leadership council with clear roles for coordination and communication.		No clear technology needs identified related to this item		
G WG Asp 1.6: There is a need for staff support for the enterprise.		No clear technology needs identified related to this item		
G WG Asp 1.7: It is essential to have authority to move forward, to implement plans – and it may need to be established legally to seek funds. Need the legal responsibility to fulfill the mission.		No clear technology needs identified related to this item		
G WG Asp 1.8: The description of the Arizona and Minnesota models is helpful and makes sense – more information about current status of Minnesota effort is needed.		No clear technology needs identified related to this item		
G WG Asp 1.9: An incremental process is expected, as in Minnesota.				

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G WG Asp 1.10: The building block concept described in the AHIMA work book is helpful – once problems are identified can then devote energy to addressing them. Don't need to have the whole thing figured out at the beginning - will need to be adaptable.				
G WG Asp 1.11: This group needs to agree on the vision and understand why existing organizations cannot carry the eHealth governance role.				
G WG Asp 1.12: Leadership of WCHQ, WHIO, WHIE, WHA, other provider and consumer representatives would be the core membership.				
G WG Asp 1.13: A small group is essential so existing initiatives are not slowed down– too big and there are many problems - can always expand as appropriate.				
G WG Asp 1.14: This would be a strategic body with low operating costs – probably not research or grant funded and should not compete for funding with other current initiatives.				

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G WG Asp 1.15: There is real added value to convene leaders, align interests, build synergy about how these various initiatives can come together and to take ownership of the goals for health information exchange.				
G WG Asp 1.16: May not need to maintain the existing eHealth Board if a new structure is created – if maintain two organizations they would have to be closely linked so as not to be redundant and uncoordinated.				
G WG Asp 1.17: A key issue for the future is funding.				
F WG Asp 1.6: The system requires re-engineering processes and workflow, and adoption phase-in will incur productivity costs.				
F WG Asp 1.7: The system requires consistency of platforms and standards for inter-operability.				
F WG Asp 1.8: Approach must be statewide, politically feasible, consistent with federal initiatives.				
F WG Asp 1.9: Must accommodate existing efforts and incorporate legacy systems. Avoid creating multiple login environments where HIT exists but interface capability is currently lacking.				

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F WG Asp 1.10: Low-volume—particularly low-volume unaffiliated—organizations may need help implementing EHR systems.				
F WG Asp 1.12: HIE will allow for flexible flow of clinical data across systems and referral centers, rather than limiting access within existing referral relationships and proprietary networks.				
F WG Asp 1.14: HIE functions most commonly pursued in the first two years are as follows: clinical messaging, medication reconciliation, PH outbreak surveillance, electronic referrals and authorizations, electronic signature, e-prescribing, P4P/quality data reporting, electronic billing support. (eHealth Initiative ToolKit)				